

Empl ID:
Agency:
Location:

Health Care and Benefits Division
PO Box 200127
Helena MT 59620-0127

INDIVIDUAL BENEFITS STATEMENT FORM

INSTRUCTIONS & DEADLINE FOR ELECTIONS - Review your elections carefully by verifying the types and amounts of coverage, reviewing benefit offerings in your Annual Change booklet, and making any necessary changes to the appropriate sections of this form or online by the October 22, 2007 deadline. All forms must be postmarked by **October 22, 2007** and returned to the Health Care and Benefits Division. Forms may be sent through the U.S. Post Office mail service, through the State of Montana (Deadhead) mail service, or dropped off at 125 N. Roberts, room 125. Giving your form to your employer or payroll personnel does not constitute filing with the Health Care and Benefits Division. **If you have NO changes, AND do not wish to enroll in Flexible Spending, Vision, or Long Term Disability, you do not need to return this form. If you completed your enrollment on-line, do not submit this form.**

BENEFIT OPTIONS	* 2007 COVERAGE	2007 PREMIUMS	2008 PREMIUMS
Medical	.	.	.
Dental	.	.	.
Vision	.	.	.
Basic Life (Plan A)	.	.	.
Dependent Life (Plan B)	.	.	.
Employee Supplemental (Plan C)	.	.	.
Spouse Supplemental (Plan D)	.	.	.
AD&D (Plan E)	.	.	.
Long-Term Care	.	.	.
Pre-Tax Plan	.	.	.
Long Term Disability	.	.	.
State Contribution	.	.	.
TOTAL OUT-OF-POCKET PREMIUM COSTS	.	.	.

*As of September 7, 2007

Member & Dependent Information: Please verify that the information for the following currently covered dependents is accurate making changes where necessary. If a dependent's tax status has changed, complete a Declaration of Tax Status form available online at www.benefits.mt.gov.

Delete	Add	Coverage**	Name	Birthdate	Relationship*	Social Security #	Tax Status
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						

*Rel. = Relationship • E = Employee • SP = Spouse • D = Daughter • S = Son • X = Disabled

**Coverage = • M = Medical • D=Dental • V=Vision

I. MEDICAL - Required for all employees. This is a one time opportunity to add dependents during Annual Change. To add dependents to medical, check the **Add** box above and write in the coverage type “M”. Delete a dependent from coverage by checking the **Delete** box preceding each dependent’s name and circle the type of coverage to be deleted.

☐ No changes

☐ Change Medical Plan to: ☐ Traditional ☐ Blue Choice ☐ New West ☐ Peak Health

All Joint Core election changes must be made on this form, not on-line.

- ☐ Elect Joint Core* (only for married spouses who are both employed by the State and have covered dependents)
*Employee’s Joint Core Partner & SSN _____
☐ Cancel Joint Core (Spouse must also submit their Individual Benefit Statement to cancel.)

ADMINISTRATIVE USE ONLY			
Date Benefit Statement received/postmarked: _____			
Date additional forms sent: _____			
By whom: _____			
Forms sent:			
<input type="checkbox"/> Life Insurance Application	FSA Type	Monthly Deduction	# of Deductions
<input type="checkbox"/> Life Insurance Enollment/Change Form			Annual Election
<input type="checkbox"/> Long-term Care Enrollment Kit	Medical	_____	12 _____
	Dependent Care	_____	12 _____

Name:
Emp ID:
Home Phone:
Work Phone:

II. DENTAL - Required for all employees

- ☐ No changes
- ☐ Changes: ☐ Add a dependent(s): check the **Add** box on front of page, write coverage type “D” and the other requested information.
☐ Delete a dependent(s): check the **Delete** box in the dependent section next to the appropriate dependent(s) and circle the coverage to be deleted.

III. VISION COVERAGE - Enrollment is not automatic! Please choose the appropriate box below. If you wish to cover dependents that are not already listed in the dependent section on the front of this form, please check the **Add** box and write coverage type “V” and the other requested information.

- ☐ Employee only coverage
 ☐ No, I do NOT want to enroll
- ☐ Employee and spouse
- ☐ Employee and children
- ☐ Employee and family

IV. LIFE INSURANCE - Basis for calculating minimum and maximum coverage \$

Check out the new opportunity to get up to \$10,000 in spouse life (plan D) without evidence of insurability in your Annual Change booklet.

- ☐ No changes
- ☐ Changes:
- ☐ **Plan B - Dependent Life**
- ☐ Cancel
- ☐ **Plan C - \$5,000 increments up to \$500,000** (*Applications will be sent if desired amount is higher than current coverage.*)
- ☐ Cancel
- ☐ Add or Change - New total amount: _____
- ☐ **Plan D - \$5,000 increments up to 100% of Plan C** (*Applications will be sent if new election or increase exceeds \$10,000*)
- ☐ Cancel
- ☐ Add or Change - New total amount: _____
- ☐ **Plan E with dependents - \$25,000 increments up to \$500,000**
- ☐ Cancel
- ☐ Add or Change - New total amount: _____
- ☐ **Plan E without dependents - \$25,000 increments up to \$500,000**
- ☐ Cancel
- ☐ Add or Change - New total amount: _____

V. PRE-TAX PLAN - Required for FSA participants and to have qualifying out-of-pocket expenses withheld on a pre-tax basis. Your current election will automatically continue, unless you indicate otherwise below. All Pre-tax election changes must be made on this form, not on-line.

- ☐ No changes ☐ Yes, I want my deductions withheld on a pre-tax basis ☐ No, I want my deductions withheld on an after-tax basis

VI. LONG TERM DISABILITY INSURANCE - Guaranteed issue for 2008!

- ☐ No changes ☐ Yes, I want to enroll ☐ No, I do NOT want to enroll

VII. FLEXIBLE SPENDING ACCOUNTS - Enrollment is NOT automatic! You must select an account and indicate an amount to enroll in an FSA during 2008. If you elect an FSA, you must also participate in the Pre-Tax Plan.

Please calculate BOTH your Monthly & Yearly FSA amounts keeping in mind the monthly amount must be divisible evenly by two. Your election will be adjusted to an even amount if necessary. Include any unused State Benefits Contribution in this amount. There is an \$2.16 per month administrative fee.

- ☐ Medical Expense FSA _____ **MONTHLY AMT** (\$10 min./\$416.66 monthly max)
 _____ **YEARLY AMT** (\$120 min./\$4999.92 yearly max)
- ☐ Dependent Care FSA _____ **MONTHLY AMT** (\$10 min./\$416.66 monthly max.)
 _____ **YEARLY AMT** (\$120 min./\$4999.92 household yearly max)

VIII. LONG-TERM CARE INSURANCE

- ☐ No changes ☐ Please send me an enrollment kit ☐ Cancel

VIII. READ AND SIGN

I request the election changes indicated above and authorize the associated payroll deduction. I understand that a Confirmation Statement to confirm my 2008 benefits will be mailed the week of November 26, 2007. I understand that if I am adding a new dependent to my medical, dental or vision benefits, I will receive a Declaration of Tax Status form to complete and failure to this form will result in my dependents being defaulted to a non-qualified status. I understand that other application forms may be required for the changes that I have requested and I am responsible for completing and returning the application materials before processing of my requested changes will continue.

I have read the informational material describing Flexible Spending Accounts and understand the participation conditions and requirements. I request participation in the FSA(s) listed above for the 2008 Benefit Year, and authorize the State of Montana to reduce gross salary by the amounts indicated. I understand my election amount will remain in effect for the entire Benefit Year, and only eligible expenses incurred during the Benefit Year (2008) may be claimed for reimbursement. I realize this agreement will **NOT** continue for subsequent Benefit Years. This agreement revokes all prior Employee Enrollment/Change and Salary Reduction Agreements signed by me for this benefit year.

Signature: _____ Date: _____